

**Acknowledgement of Financial Responsibility Practices  
And  
Acknowledge of Notice of Privacy Practices (HIPAA)**

**By my signature below I acknowledge:**

- **My receipt and/or acceptance of the Notice of Financial Responsibility Practices and Notice of Privacy Practices (HIPAA) for Breakthru Physical Therapy.**
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When necessary to process insurance claims for medical treatment or services rendered to me, I expressly authorize:

- The release of any medical information about me by any holder of said information to any insurance carrier who may provide financial assistance for this treatment or service;
- The release to the Centers for Medicare and Medicaid and/or to the Health Care Financing Administration and its agent(s) of any medical information necessary to determine benefits;
- The payment by my insurance carrier(s) of insurance and/or Medicare benefits directly to Breakthru Physical Therapy for services rendered.

I accept financial responsibility to Breakthru Physical Therapy if my insurance does not pay for my services and/or the remaining balance(s) from what my insurance company has paid as discussed prior to the onset of my treatment.

\_\_\_\_\_  
Patient's Name (Print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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OFFICE USE ONLY

\_\_\_\_\_ was given a copy of the Notice of Financial Responsibility and the Notice of Privacy Practice (HIPAA).

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ refused to sign.

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_